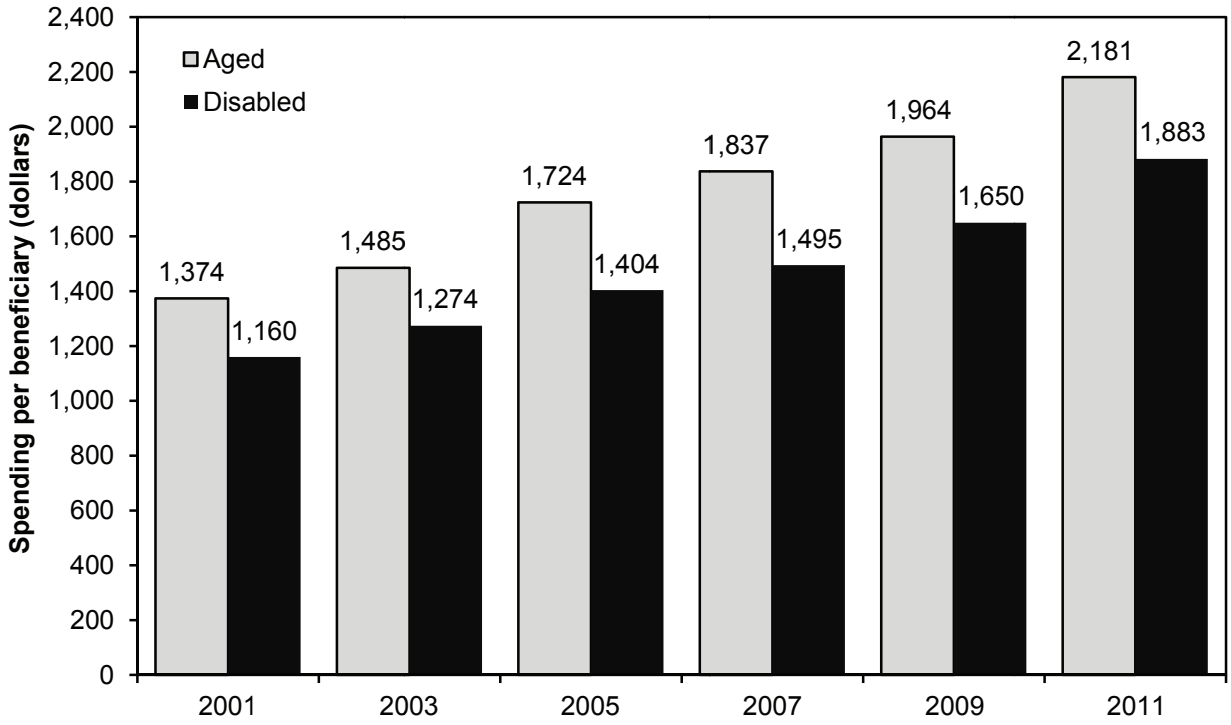
SECTION 7

Ambulatory care

Physicians
Hospital outpatient services
Ambulatory surgical centers
Imaging services

Chart 7-1. Medicare spending per FFS beneficiary on physician fee-schedule services, 2001–2011



Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance. The category "disabled" excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries age 65 or over are included in the aged category.

Source: 2011 and 2012 annual reports of the Boards of Trustees of the Medicare trust funds.

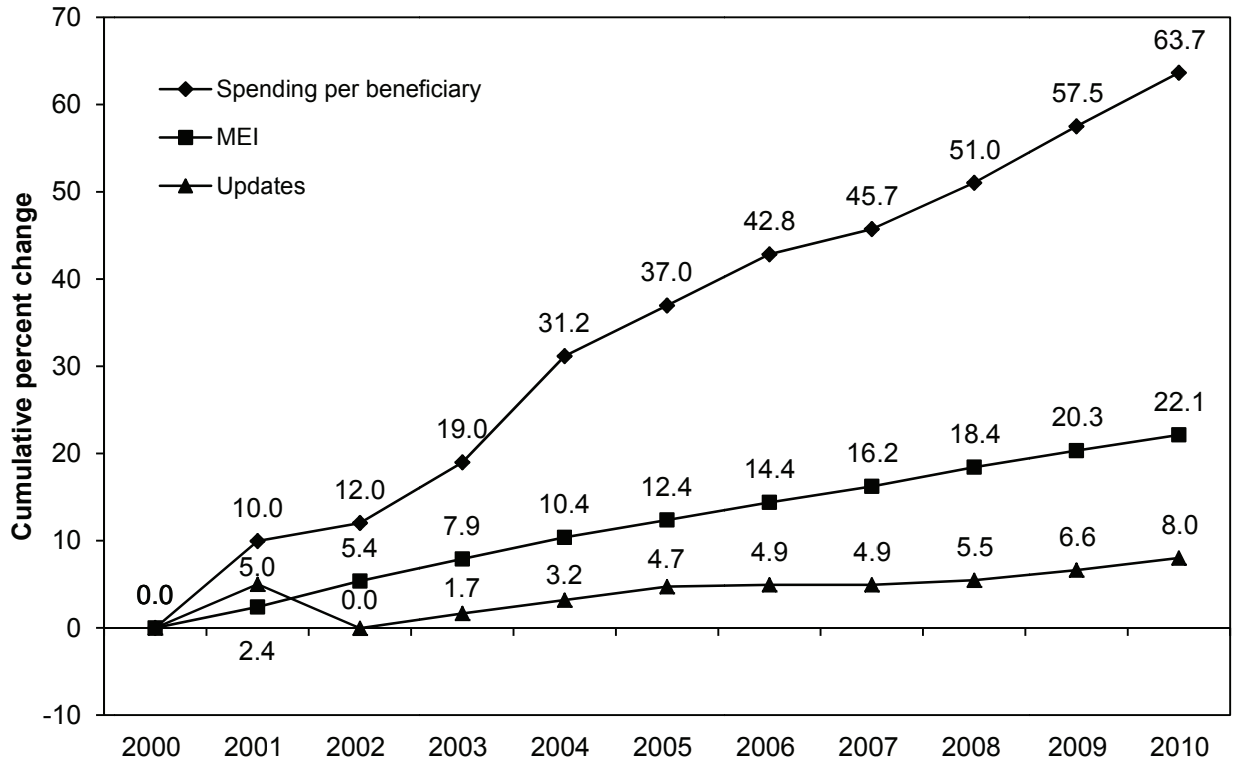
- Physicians and other health professionals perform a broad range of services in the Medicare physician fee schedule, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services furnished in all health care settings. In addition to physicians, these services may be provided by other health professionals (e.g., nurse practitioners, chiropractors, and physical therapists).

- FFS spending per beneficiary for physician fee-schedule services has increased annually. From 2001 to 2011, Medicare spending per FFS beneficiary on these services grew 58 percent.

- Growth in spending on physician fee-schedule services is one of several contributions to Part B premium increases over this time period.

- Per capita spending for disabled beneficiaries (under age 65) is lower than per capita spending for aged beneficiaries. In 2011, for example, per capita spending for disabled beneficiaries was $1,883 compared with $2,181 for aged beneficiaries.

Chart 7-2. Volume growth has raised physician spending more than input prices and payment updates, 2000–2010

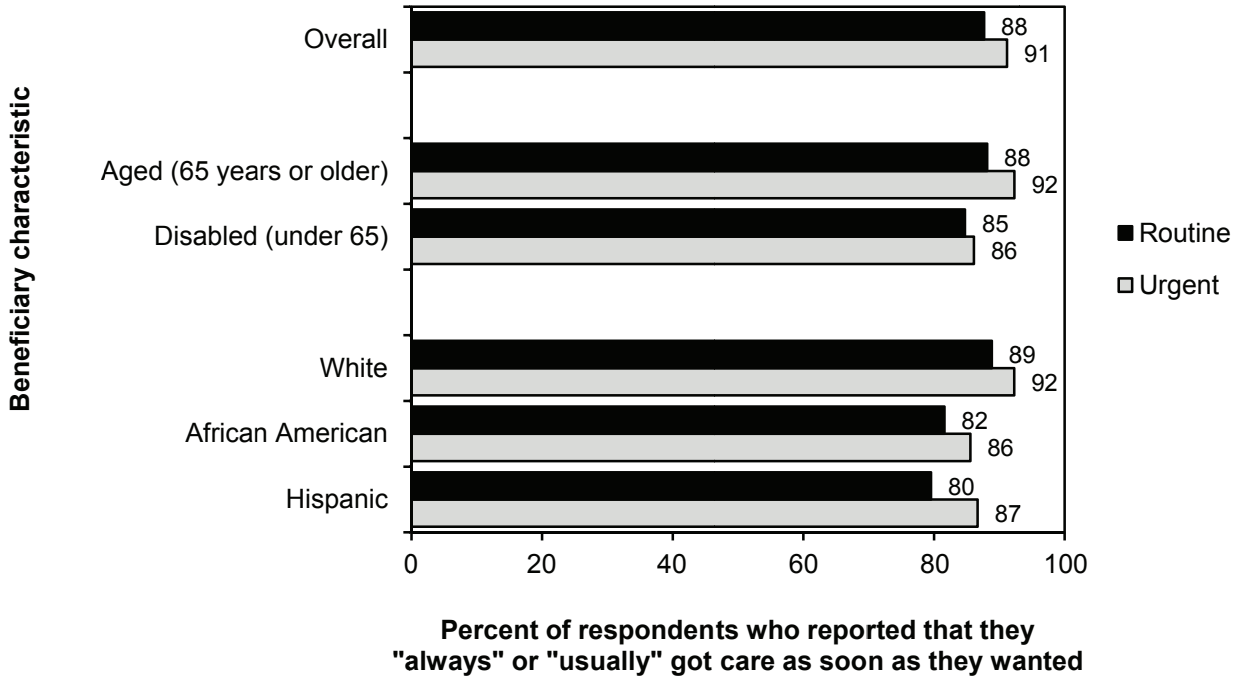


Note: MEI (Medicare Economic Index).

Source: 2011 annual report of the Boards of Trustees of the Medicare trust funds, IHS Global Insight data through fourth quarter of 2010, and data from the Office of the Actuary.

- From 2000 to 2010, Medicare spending for physician services—per beneficiary—increased by 64 percent.
- This spending grew much more rapidly over the period than both the payment rate updates and the MEI. Physician fee schedule payment updates totaled 8 percent, and the MEI increased 22 percent.
- Growth in the volume of services contributed much more to the rapid increase in Medicare spending than payment rate updates. Both factors—updates and volume growth—combine to increase physician revenues.

Chart 7-3. Most beneficiaries report that they can always or usually get timely care, 2011



Note: In the survey, routine care refers to appointments in doctors' offices or clinics that are not for care needed "right away." Urgent care refers to care needed "right away" for an illness, injury, or condition. Nonapplicable respondents (e.g., those who did not seek routine or urgent care in the last six months) were excluded.

Source: MedPAC analysis of CAHPS® (Consumer Assessment of Healthcare Providers and Systems®) for fee-for-service Medicare, 2011.

- Overall, 88 percent of Medicare beneficiaries who reported making an appointment for routine care at a doctor's office or clinic said that they always or usually got care as soon as they wanted. For beneficiaries who reported needing urgent care in a clinic, emergency room, or doctor's office, 91 percent reported that they always or usually got care as soon as they wanted.

- Compared with beneficiaries age 65 or older, those under age 65 and eligible for Medicare on the basis of disability were less likely to report that they always or usually got routine or urgent care as soon as they wanted.

- Smaller percentages of African American and Hispanic beneficiaries reported that they always or usually got care as soon as they wanted, compared with White beneficiaries.

Chart 7-4. Medicare beneficiaries report better ability to get timely appointments with physicians, compared with privately insured individuals, 2008–2011

	Medicare (age 65 or older)				Private insurance (age 50–64)			
Survey question	2008	2009	2010	2011	2008	2009	2010	2011
Unwanted delay in getting an appointment: Among those who needed an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"								
For routine care								
Never	76%[a]	77%[a]	75%[a]	74%[a]	69%[a]	71%[a]	72%[a]	71%[a]
Sometimes	17[a]	17[a]	17[a]	18[a]	24[a]	22[a]	21[a]	21[a]
Usually	3[a]	2[ab]	3[a]	3	5[a]	3[a]	4[a]	4
Always	2	2	2	2[a]	2	3	3	3[a]
For illness or injury								
Never	84[a]	85[ab]	83[a]	82	79[a]	79[a]	80[a]	79
Sometimes	12[a]	11[ab]	13[a]	14[a]	16[a]	17[a]	15[a]	17[a]
Usually	1	2	2	2	2	2	2	2
Always	1[a]	1	1[a]	1	2[a]	2	2[a]	1

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 3,000 in 2008 and 4,000 in years 2009, 2010, and 2011. Sample sizes for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.
[b] Statistically significantly different (at a 95 percent confidence level) from 2011 within the same insurance coverage category.

Source: MedPAC-sponsored telephone surveys, conducted in 2008, 2009, 2010, and 2011.

- Most Medicare beneficiaries have one or more doctor appointments in a given year. Therefore, one access indicator we examine is their ability to schedule timely appointments.
- Medicare beneficiaries report better access to physicians for appointments compared with privately insured individuals age 50 to 64. For example, in 2011, 74 percent of Medicare beneficiaries and 71 percent of privately insured individuals reported "never" having to wait longer than they wanted to get an appointment for routine care.
- Medicare beneficiaries also report more timely appointments for injury and illness compared with their privately insured counterparts.
- As expected, appointment scheduling for illness and injury is better than for routine care appointments for both Medicare beneficiaries and privately insured individuals.

Chart 7-5. Medicare and privately insured patients who are looking for a new physician report more difficulty finding one in primary care, 2008–2011

	Medicare (age 65 or older)				Private insurance (age 50–64)			
Survey question	2008	2009	2010	2011	2008	2009	2010	2011
Looking for a new physician: "In the past 12 months, have you tried to get a new …?" (Percent answer "Yes")								
Primary care physician	6%	6%	7%	6%	7%	8%	7%	7%
Specialist	14[a]	14[a]	13[a]	14[a]	19[a]	19[a]	15[a]	16[a]
Getting a new physician: Among those who tried to get an appointment with a new physician, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it…"								
Primary care physician								
No problem	71	78[b]	79[ab]	65	72	71	69[a]	68
Small problem	10	10	8	12	13	8[b]	12	16
Big problem	18	12[ab]	12[b]	23[a]	13	21[a]	19	14[a]
Specialist								
No problem	88	88	87[a]	84	83	84	82[a]	86
Small problem	7	7	6[a]	8	9	9	11[a]	8
Big problem	4	5	5	7	7	7	6	6

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 3,000 in 2008 and 4,000 in years 2009, 2010, and 2011. Sample sizes for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.
[b] Statistically significantly different (at a 95 percent confidence level) from 2011 within insurance coverage category.

Source: MedPAC-sponsored telephone surveys, conducted in 2008, 2009, 2010, and 2011.

- In 2011, only 6 percent of Medicare beneficiaries and 7 percent of privately insured individuals reported looking for a new primary care physician. This finding suggests that most people are either satisfied with their current physician or did not have a need to look for one.

- Of the 6 percent of Medicare beneficiaries who were looking for a new primary care physician in 2011, 35 percent reported problems finding one—23 percent reporting their problem as "big" plus 12 percent reporting their problem as "small." Although this number amounts to about 2 percent of the total Medicare population reporting problems, the Commission is concerned about the continuing trend of greater access problems for primary care.

  Of the 7 percent of privately insured individuals who were looking for a new primary care physician in 2011, 30 percent reported problems finding one—14 percent reporting their problem as "big" plus 16 percent reporting their problem as "small."

- For 2011, Medicare beneficiaries and privately insured individuals were more likely to report problems accessing a new primary care physician compared with a new specialist.

Chart 7-6. Access to physician care is better for Medicare beneficiaries compared with privately insured individuals, but minorities in both groups report problems more frequently, 2011

	Medicare (age 65 or older)			Private insurance (age 50–64)		
Survey question	All	White	Minority	All	White	Minority
Unwanted delay in getting an appointment: Among those who needed an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	74%[a]	75%	72%[a]	71%[a]	72%[b]	64%[ab]
Sometimes	18[a]	19	18[a]	21[a]	21[b]	25[ab]
Usually	3	4	3	4	4	4
Always	2[a]	2[ab]	3[ab]	3[a]	3[ab]	6[ab]
For illness or injury						
Never	82	83[b]	75[b]	79	81[b]	75[b]
Sometimes	14[a]	13[ab]	17[b]	17[a]	16[a]	19
Usually	2	2	2	2	2	3
Always	1	1[b]	2[b]	1	1[b]	2[b]

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in 2011. Sample sizes for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given race category.
[b] Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys, conducted in 2011.

- In 2011, Medicare beneficiaries reported better access to physicians for appointments compared with privately insured individuals age 50 to 64.
- Access varied by race, with minorities more likely than Whites to report access problems in both insurance categories. For example, in 2011, 83 percent of White Medicare beneficiaries reported "never" having to wait longer than they wanted to get an appointment for an illness or injury compared with 75 percent of minority beneficiaries.
- Although minorities experienced more access problems, minorities with Medicare were less likely to experience problems than minorities with private insurance.

Chart 7-7. Differences in access to new physicians are most apparent among minority Medicare and privately insured patients who are looking for a new specialist, 2011

	Medicare (age 65 or older)			Private insurance (age 50–64)		
Survey question	All	White	Minority	All	White	Minority
Looking for a new physician: "In the past 12 months, have you tried to get a new …?"						
Primary care physician	6%	6%	6%	7%	6%	6%
Specialist	14[a]	16[b]	9[ab]	16[a]	17[b]	13[ab]
Getting a new physician: Among those who tried to get an appointment with a new physician, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it…"						
Primary care physician						
No problem	65	67	57	68	72	58
Small problem	12	10	19	16	15	19
Big problem	23[a]	23[a]	23	14[a]	12[a]	18
Specialist						
No problem	84	86[b]	65[ab]	86	88[b]	78[ab]
Small problem	8	7	11	8	8	10
Big problem	7	6[b]	19[b]	6	5[b]	11[b]

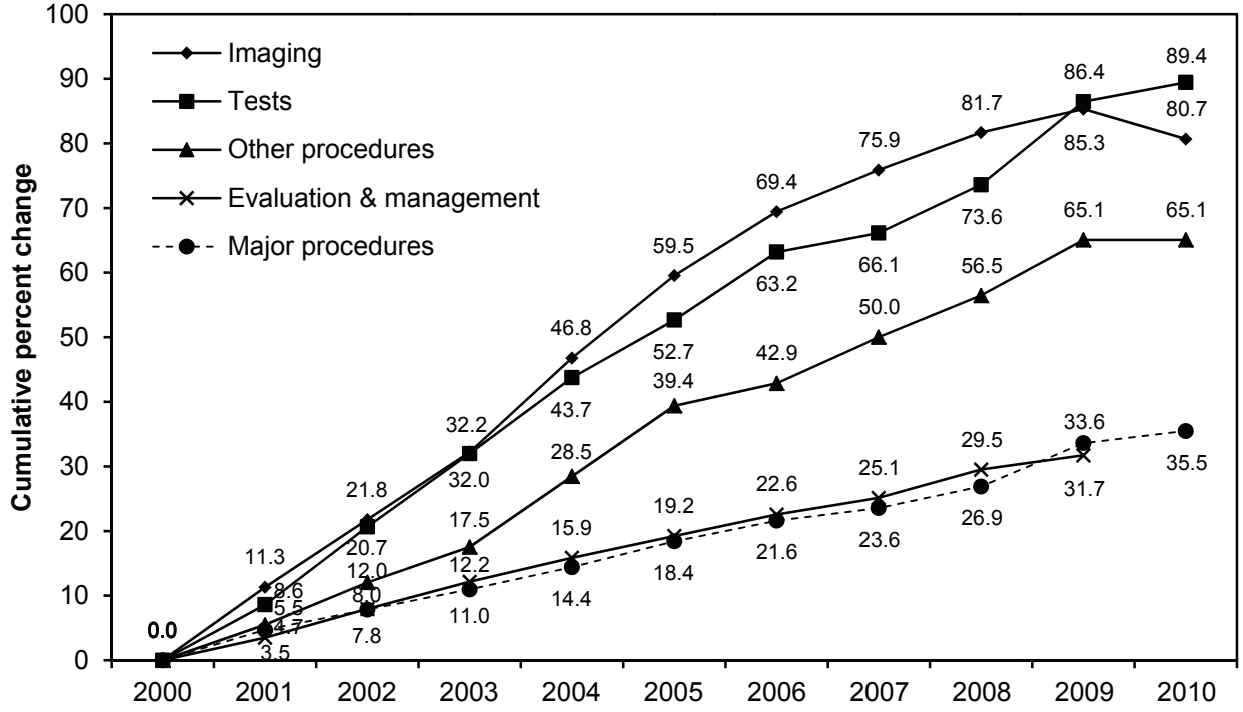
Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in 2011. Sample sizes for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given race category.
[b] Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys, conducted in 2011.

- Among the small percentage of Medicare beneficiaries and privately insured individuals looking for a new specialist, minorities were more likely than Whites to report problems finding one. For example, in 2011, 86 percent of White Medicare beneficiaries reported "no problem" finding a new specialist, compared with 65 percent of minority beneficiaries.

- Although minorities experienced more access problems, minorities with Medicare were less likely to experience problems than minorities with private insurance.

Chart 7-8. Growth in volume of physician fee schedule services per beneficiary, 2000–2010



Note: Volume is units of service multiplied by relative value units from the physician fee schedule. Volume for all years is measured on a common scale, with relative value units for 2010. Volume growth for evaluation and management is through 2009 only due to change in payment policy for consultations.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

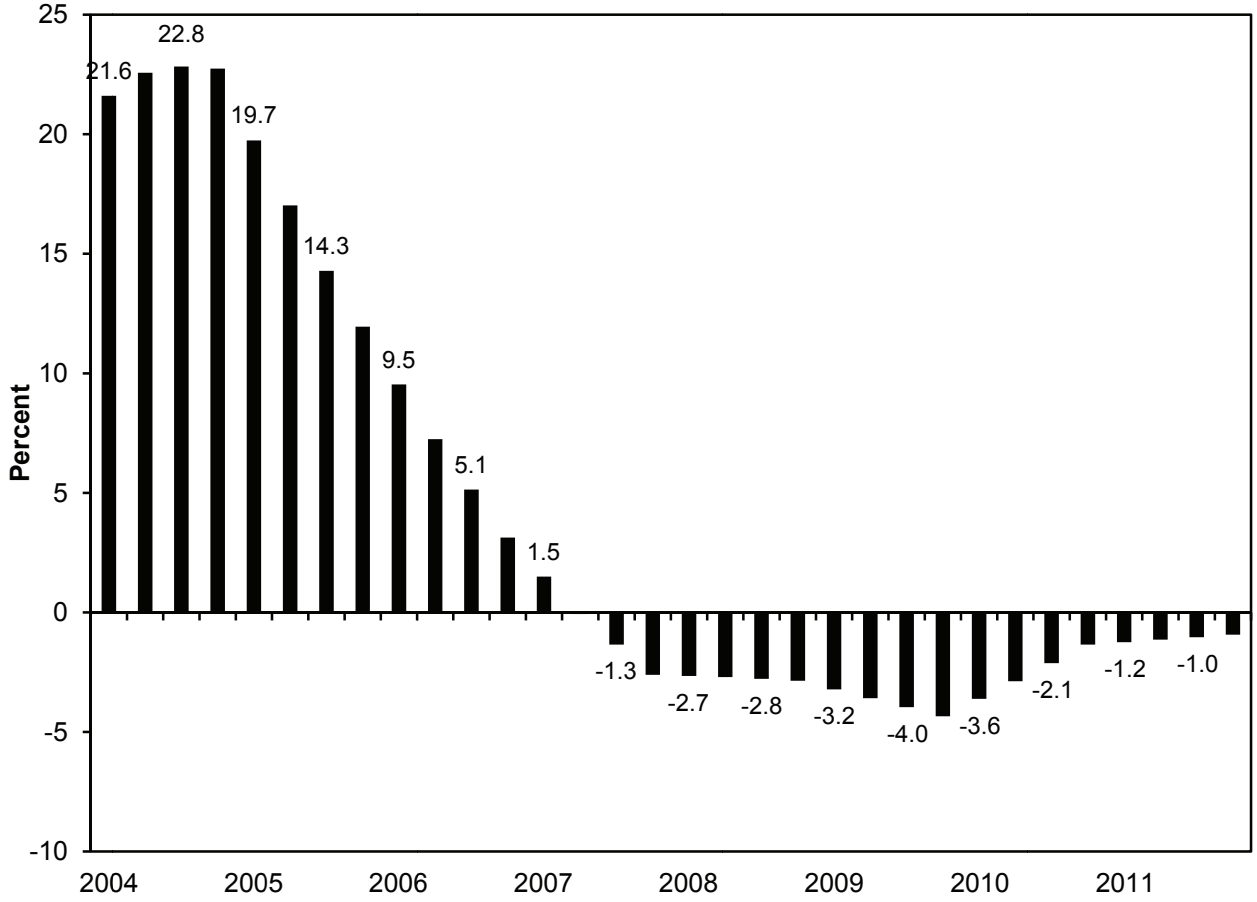
- From 2000 to 2010, the volume of some services furnished by physicians and other professionals grew much more than others.

- The volume of tests grew by 89 percent, the volume of imaging grew by 81 percent, and the volume of "other procedures" (procedures other than major procedures) each grew by 65 percent. The comparable growth rate for major procedures was only 35 percent. While we could not calculate the volume growth rate for evaluation and management (E&M) through 2010 because of a change in payment policy for consultations, the growth rate for E&M through 2009 was similar that for major procedures and, therefore, was much lower than the rates for tests, imaging, and other procedures.

- While the volume of imaging decreased by 2.5 percent from 2009 to 2010, this decrease is small when compared to the increases that had occurred previously. From 2000 to 2009, cumulative growth in the volume of imaging totaled 85 percent.

- Volume growth increases Medicare spending, squeezing other priorities in the federal budget and requiring taxpayers and beneficiaries to contribute more to the Medicare program. Overall volume increases translate directly to growth in both Part B spending and premiums. They are also largely responsible for the negative updates required by the sustainable growth rate formula. Rapid volume growth may be a sign that some services in the physician fee schedule are mispriced.

Chart 7-9. Changes in physicians' professional liability insurance premiums, 2004–2011



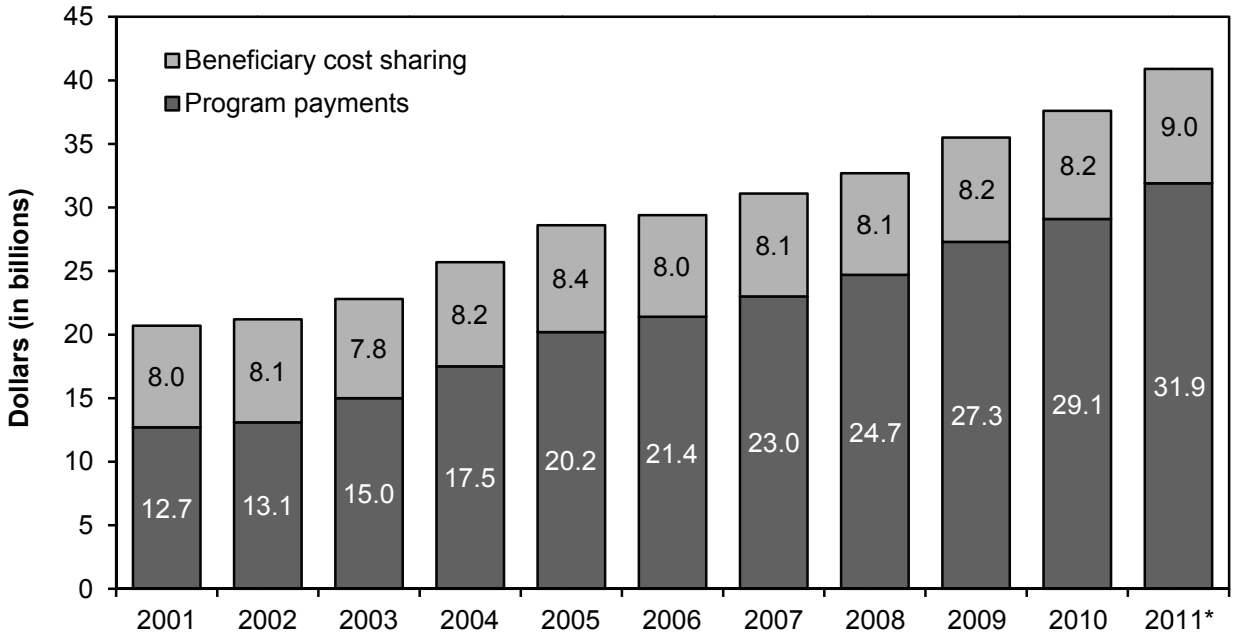
Note: Bars represent a four-quarter moving average percent change.

Source: CMS, Office of the Actuary. Data are from CMS's Professional Liability Physician Premium Survey.

- Professional liability insurance (PLI) accounts for 4.3 percent of total payments under the physician fee schedule. PLI premiums generally follow a cyclical pattern, alternating between periods of low premiums—characterized by high investment returns for insurers and vigorous competition—and high premiums—characterized by declining investment returns and market exit.

- After rapid increases in PLI premiums between 2002 and 2004, premium growth slowed in 2005 and 2006, becoming negative in 2007 and remaining negative through 2011.

Chart 7-10. Spending on all hospital outpatient services, 2001–2011



Note: Spending amounts are for services covered by the Medicare outpatient prospective payment system and those paid on separate fee schedules (e.g., ambulance services and durable medical equipment) or those paid on a cost basis (e.g., corneal tissue acquisition and flu vaccines). They do not include payments for clinical laboratory services.
*Estimate.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services (excluding clinical laboratory services) from calendar year 2001 to 2011 increased by 98 percent, reaching $41.0 billion. The Office of the Actuary projects continued growth in total spending, averaging 9.2 percent per year from 2008 to 2013.

- A prospective payment system (PPS) for hospital outpatient services was implemented in August 2000. Services paid under the outpatient PPS represent most of the hospital outpatient spending illustrated in this chart, about 91 percent.

- In 2001, the first full year of the outpatient PPS, spending under the PPS was $19.0 billion, including $11.3 billion by the program and $7.6 billion in beneficiary cost sharing. Spending under the outpatient PPS represented 92 percent of the $20.7 billion in spending on hospital outpatient services in 2001. By 2011, spending under the outpatient PPS is expected to rise to $37.3 billion ($29.0 billion program spending; $8.3 billion beneficiary copayments), which is 91 percent of the $41.0 billion in spending on outpatient services in 2011. The outpatient PPS accounted for about 5 percent of total Medicare spending by the program in 2011.

- Beneficiary cost sharing under the outpatient PPS is generally higher than for other sectors, about 22 percent in 2010. Chart 7-14 provides more detail on coinsurance.

Chart 7-11. Most hospitals provide outpatient services

Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
2002	4,210	94%	84%	93%
2004	3,882	94	86	92
2006	3,651	94	86	91
2008	3,607	94	87	91
2010	3,518	95	90	89
2012	3,503	95	91	93*

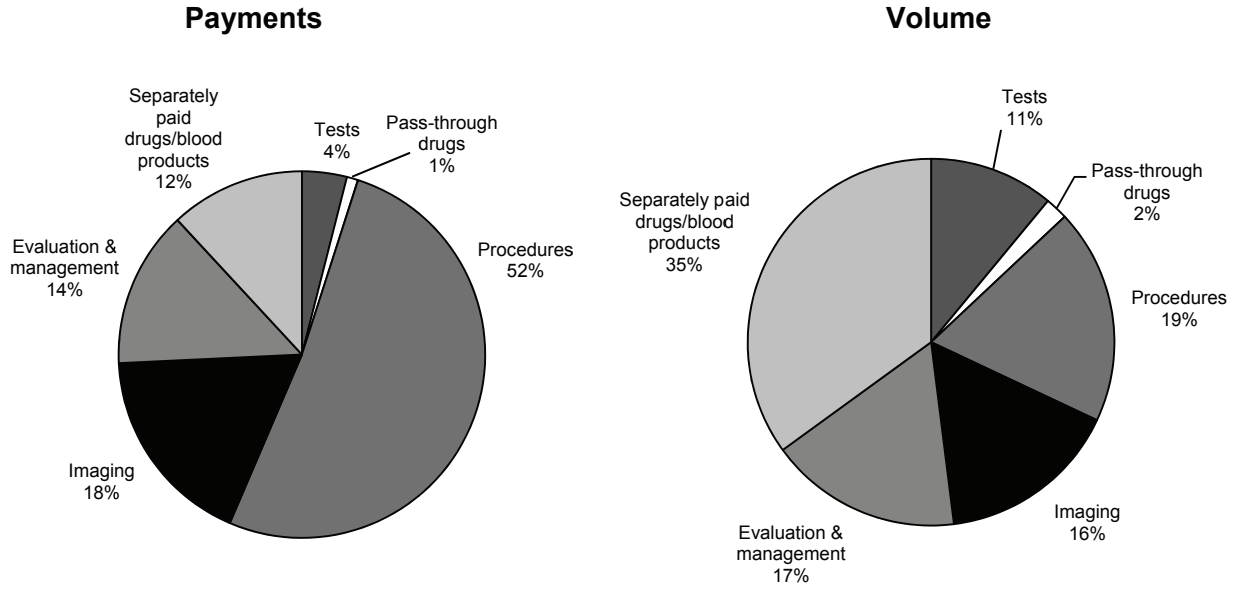
Note: Includes services provided or arranged by short-term hospitals. Excludes long-term, Christian Science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.
*The data source we used in this chart changed the variable for identifying hospitals' provision of emergency services. We believe this change in variable definition makes it appear that the percentage of hospitals providing emergency services increased sharply from 2010 to 2012, but question whether such a large increase actually occurred.

Source: Medicare Provider of Services files from CMS.

- The number of hospitals that furnish services under Medicare's outpatient prospective payment system (PPS) declined from 2002 through 2006, largely due to growth in the number of hospitals converting to critical access hospital status, which allows payment on a cost basis. Since 2006, the number of outpatient PPS hospitals has been more stable. In addition, the percent of hospitals providing outpatient services remained stable; the percent offering outpatient surgery has steadily increased; and the percent offering emergency services has decreased slightly from 2002 through 2010. The increase in the percent providing emergency services in 2012 is likely due to a change in the variable that determines whether a hospital offers emergency services.

- Almost all hospitals in 2012 provide outpatient services (95 percent). The vast majority provide outpatient surgery and emergency services.

Chart 7-12. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2010



Note: PPS (prospective payment system). Payments include both program spending and beneficiary cost sharing, but do not include hold-harmless payments to rural hospitals. Services are grouped into evaluation and management, procedures, imaging, and tests, according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicator. Percentages may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the 5 percent standard analytic file of outpatient claims for 2010.

- Hospitals provide many different types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- The payments for services are distributed differently than volume. For example, procedures account for 52 percent of payments, but only 19 percent of volume.
- Procedures (e.g., endoscopies, surgeries, skin and musculoskeletal procedures) account for the greatest share of payments for services (52 percent), followed by imaging services (18 percent) and evaluation and management services (14 percent).
- In 2010, separately paid drugs and blood products accounted for 12 percent of payments.

Chart 7-13. Hospital outpatient services with the highest Medicare expenditures, 2010

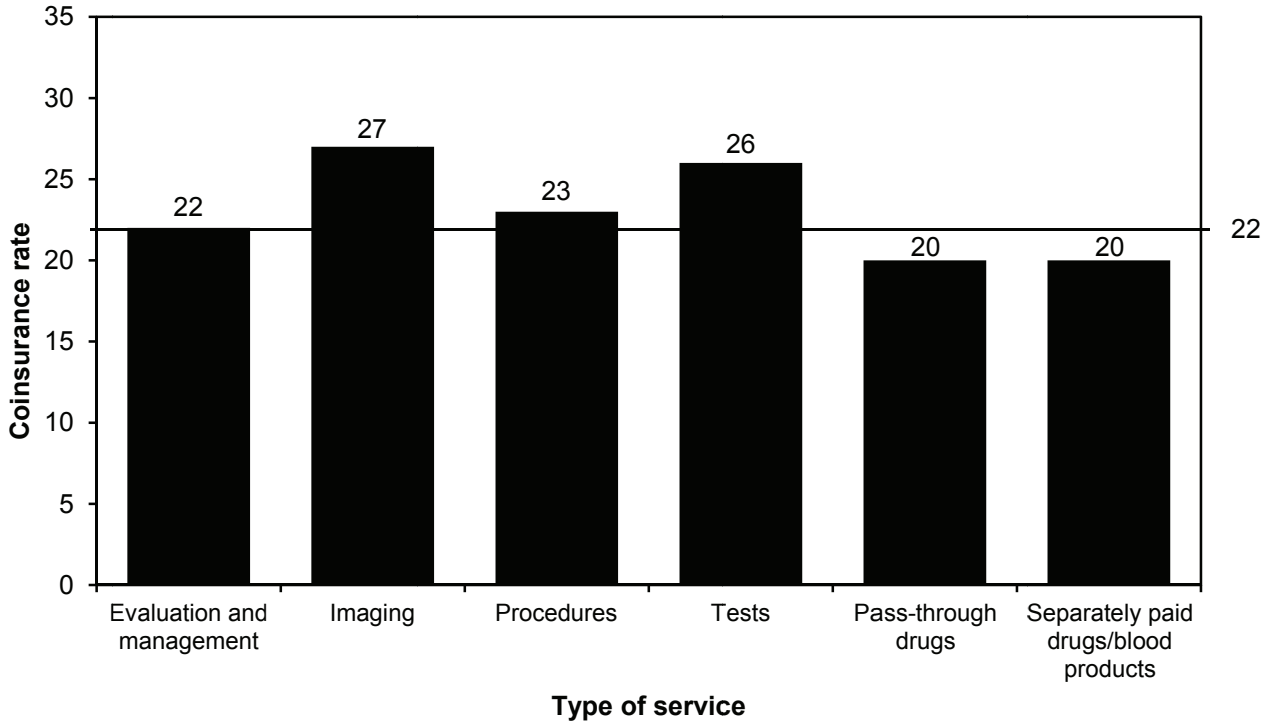
APC Title	Share of payments	Volume (thousands)	Payment rate
Total	46%		
All emergency visits	6	11,589	$188
All clinic visits	4	20,110	73
Diagnostic cardiac catheterization	3	479	2,677
CT and CTA with contrast composite	3	1,522	627
Cataract procedures with IOL insert	2	528	1,633
Level I plain film except teeth	2	15,890	45
Insertion of cardioverter-defibrillator	2	31	21,909
Lower gastrointestinal endoscopy	2	1,116	612
Level II extended assessment & management composite	2	920	704
Transcatheter placement of intracoronary drug-eluting stents	2	86	7,449
Insertion/replacement/repair of cardioverter-defibrillator leads	2	20	27,728
Coronary or noncoronary angioplasty and percutaneous valvuloplasty	1	192	3,408
IMRT treatment delivery	1	1,189	420
Computed tomography without contrast	1	2,482	195
Level II cardiac imaging	1	638	773
Level II echocardiogram without contrast	1	1,083	450
Level I upper gastrointestinal procedures	1	938	588
CT and CTA without contrast composite	1	1,085	418
Transcatheter placement of intravascular shunts	1	74	6,542
Level II laparoscopy	1	135	3,150
Level III nerve injections	1	876	484
Level III cystourethoscopy and other genitourinary procedures*	1	264	1,716
MRI and magnetic resonance angiography without contrast material	1	1,027	349
MRI and magnetic resonance angiography without contrast followed by contrast	1	607	534
Insertion/replacement/conversion of permanent dual chamber pacemaker	1	34	9,559
Average APC		349	149

Note: APC (ambulatory payment classification), CT (computed tomography), CTA (computed tomography angiography), IOL (intraocular lens), IMRT (intensity-modulated radiation therapy), MRI (magnetic resonance imaging). The payment rates for "All emergency visits" and "All clinic visits" are weighted averages of payment rates from five APCs. The percentages for the specific APCs do not add to the total of 46 because of rounding.
*Did not appear on the list for 2009.

Source: MedPAC analysis of 5 percent analytic files of outpatient claims for calendar year 2010.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a handful of categories that have high volume, high payment rates, or both.

Chart 7-14. Medicare coinsurance rates, by type of hospital outpatient service, 2010



Note: Services were grouped into categories of evaluation and management, imaging, procedures, and tests according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicators.

Source: MedPAC analysis of the 5 percent standard analytic files of outpatient claims for 2010.

- Before CMS began using the outpatient prospective payment system (PPS), beneficiary coinsurance payments for hospital outpatient services were based on hospital charges, while Medicare payments were based on hospital costs. As hospital charges grew faster than costs, coinsurance represented a large share of total payments over time.
- In adopting the outpatient PPS, the Congress froze the dollar amounts for coinsurance. Consequently, beneficiaries' share of total payments will decline over time.
- The coinsurance rate is different for each service. Some services, such as imaging, have relatively high rates of coinsurance—27 percent. Other services, such as evaluation and management services, have coinsurance rates of 22 percent.
- In 2010, the average coinsurance rate was about 22 percent.

Chart 7-15. Effects of hold-harmless and SCH transfer payments on hospitals' outpatient revenue, 2008–2010

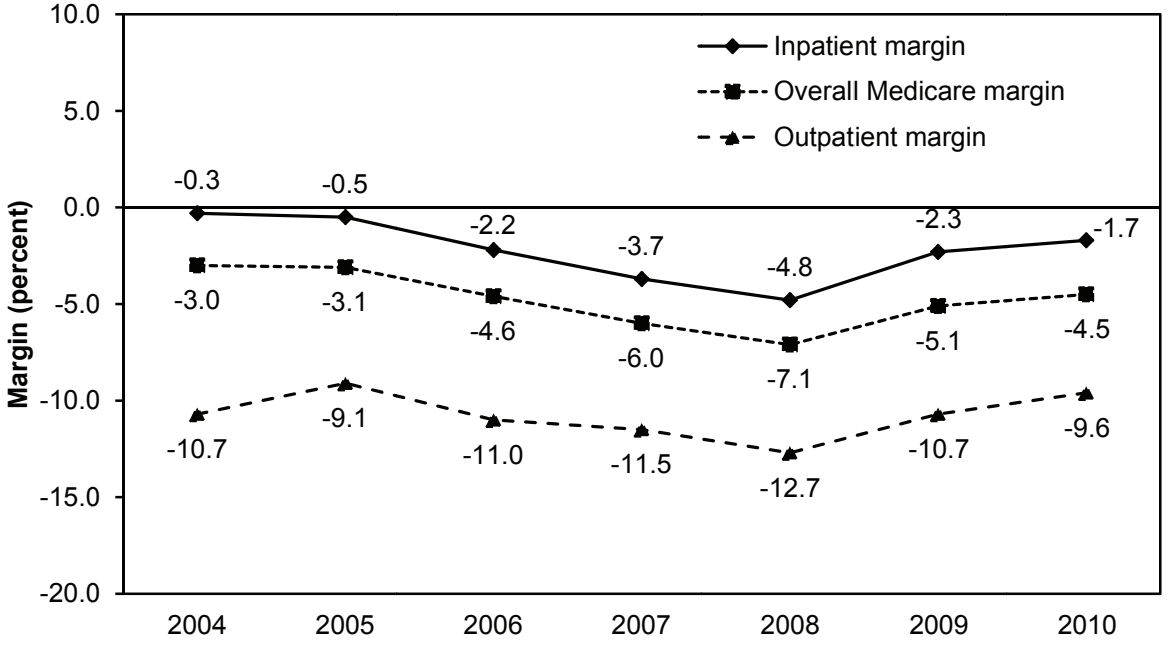
Hospital group	2008 Number of hospitals	2008 Share of payments from hold harmless and SCH transfer	2009 Number of hospitals	2009 Share of payments from hold harmless and SCH transfer	2010 Number of hospitals	2010 Share of payments from hold harmless and SCH transfer
All hospitals	3,197	0.2%	3,161	0.3%	3,094	0.4%
Urban	2,271	–0.4	2,245	–0.4	2,212	–0.3
Rural SCHs	381	5.8	383	7.2	363	7.7
Rural ≤100 beds	394	3.0	386	2.9	373	3.1
Other rural	149	–0.4	146	–0.4	145	–0.3
Major teaching	271	–0.3	270	–0.3	267	–0.3
Other teaching	714	–0.1	713	–0.2	712	–0.1
Nonteaching	2,210	0.6	2,177	0.8	2,114	1.0

Note: SCH (sole community hospital). Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Cost Report files from CMS.

- Medicare implemented the hospital outpatient prospective payment system (PPS) in 2000. Previously, Medicare paid for hospital outpatient services on the basis of hospital costs. Recognizing that some hospitals might receive lower payments under the outpatient PPS than under the earlier system, the Congress established transitional corridor payments. The corridors were designed to make up part of the difference between payments that hospitals would have received under the old payment system and those under the new outpatient PPS.
- Transitional corridor payments expired for most hospitals at the end of 2003. However, some rural hospitals continue to receive a special category of transitional corridor payments called "hold harmless." Qualifying hospitals receive the greater of the payments they would have received from the previous system or the actual outpatient PPS payments.
- Hospitals that qualified for hold-harmless payments in 2004 and 2005 included SCHs located in rural areas and other small rural hospitals (100 or fewer beds). After 2005, small rural hospitals continued to be eligible for hold-harmless payments, but SCHs no longer qualified. However, in 2006, CMS implemented a policy (the "SCH transfer") that increased outpatient payments to rural SCHs by 7.1 percent above the standard rates. This policy is budget neutral by reducing payments to all other hospitals by 0.4 percent. Finally, the Congress reestablished hold-harmless payments for SCHs that have 100 or fewer beds in 2009, and extended hold-harmless payments to all SCHs in 2010.
- Hold-harmless payments and the SCH transfer represented 0.2 percent of total outpatient PPS payments for all hospitals in 2008. However, the percentage of total outpatient payments from these policies was 5.8 percent for rural SCHs and 3.0 percent for small rural hospitals. Data from 2009 and 2010 indicate transfer and hold-harmless payments to rural SCHs were 7.2 percent of their outpatient revenue in 2009 and 7.7 percent in 2010. Small rural hospitals continued to benefit from hold-harmless payments in 2009 and 2010. These payments were 2.9 percent of their total outpatient payments in 2009 and 3.1 percent in 2010.

Chart 7-16. Medicare hospital outpatient, inpatient, and overall Medicare margins, 2004–2010



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of hospital inpatient, outpatient, psychiatric and rehabilitation services (not paid under the prospective payment system); hospital-based skilled nursing facilities and home health services; and graduate medical education.

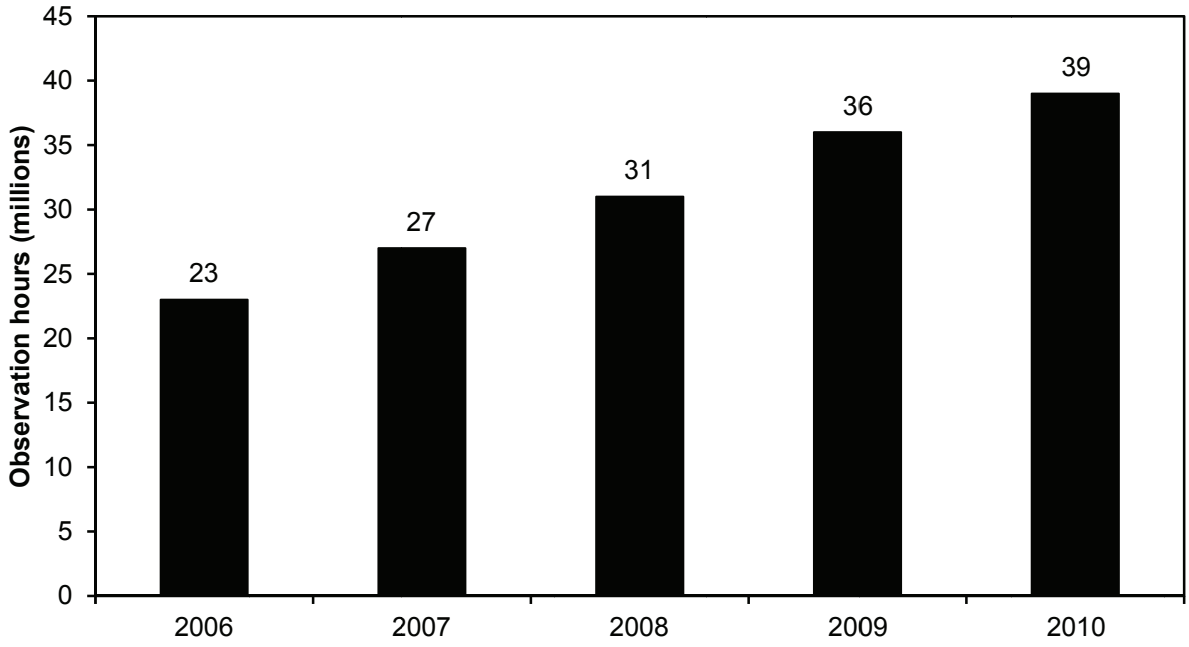
Source: MedPAC analysis of Medicare cost report data from CMS.

- Hospital outpatient margins vary. In 2010, while the aggregate margin was –9.6 percent, 25 percent of hospitals had margins of –20.7 percent or lower, and 25 percent had margins of 2.8 percent or higher. Outpatient margins also differed widely across hospital categories.

- Given hospital accounting practices, margins for hospital outpatient services must be considered in the context of Medicare payments and hospital costs for the full range of services provided to Medicare beneficiaries. Hospitals allocate overhead to all services, so we generally consider costs and payments overall.

- The improved outpatient margin in 2010 may be due to relatively low cost growth. After increasing from 2004 to 2005, the outpatient margin declined in 2006, reflecting a change in Medicare's reimbursement for Part B drugs and an end to hold-harmless payments to SCHs (which were reestablished in 2009). The margin declined again in 2007 and 2008, which may be partly due to lower hold-harmless payments for hospitals that still qualify for them. The improved margin in 2009 may be due to low cost growth and expansion of hold-harmless payments to sole community hospitals.

Chart 7-17. Number of observation hours has increased, 2006–2010



Source: MedPAC analysis of Limited Data Set claims for the outpatient prospective payment system, 2006–2010.

- Hospitals use observation care to determine whether a patient should be hospitalized for inpatient care or sent home.
- Medicare began providing separate payments to hospitals for some observation services on April 1, 2002. Previously, the observation services were packaged into the payments for the emergency room or clinic visits that occur with observation care.
- The number of observation hours (both packaged and separately paid) has increased substantially from about 23 million in 2006 to 39 million in 2010. Before 2006, it was difficult to count the total number of observation hours because hospitals were not required to record on claims the number of hours for packaged observation hours.

Chart 7-18. Number of Medicare-certified ASCs increased by 33 percent, 2004–2011

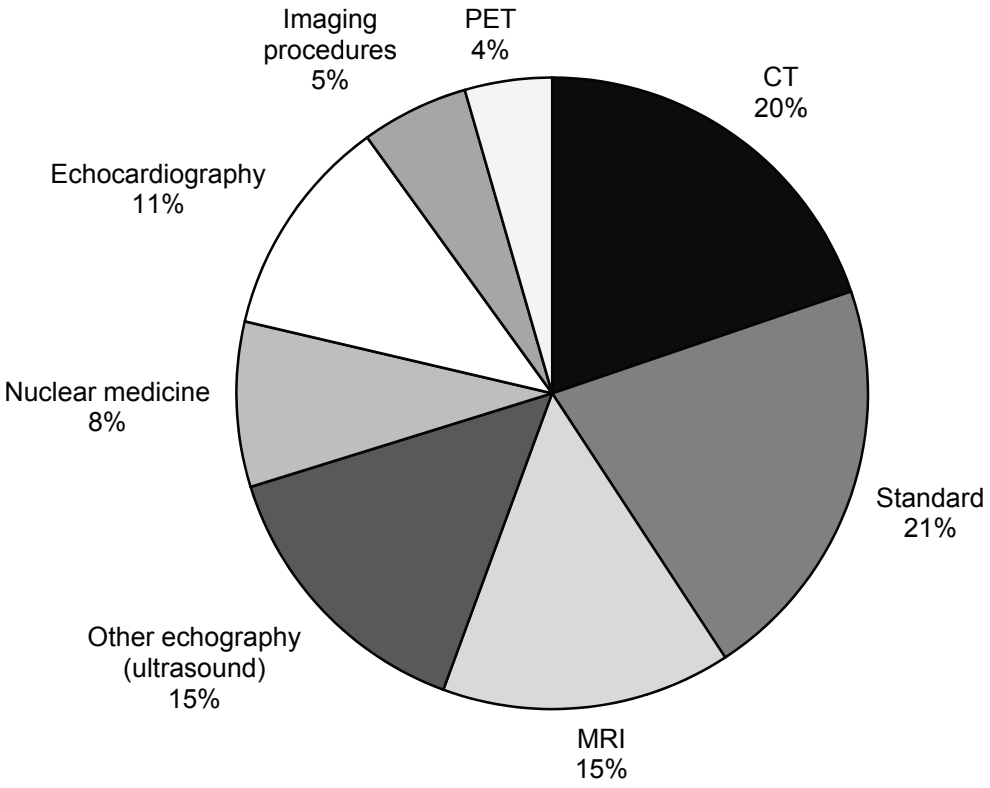
	2004	2005	2006	2007	2008	2009	2010	2011
Medicare payments (billions of dollars)	$2.5	$2.7	$2.8	$2.9	$3.1	$3.2	$3.3	$3.5
Number of centers	4,033	4,328	4,567	4,838	5,045	5,157	5,252	5344
New centers	367	354	328	345	281	218	189	153
Exiting centers	81	59	89	74	74	106	94	61
Net percent growth in number of centers from previous year	6.7%	7.3%	5.5%	5.9%	4.3%	2.2%	1.8%	1.8%
Percent of all centers that are:								
For profit	96	96	96	96	96	96	97	97
Nonprofit	4	4	4	4	4	3	3	3
Urban	91	91	91	91	91	91	91	91
Rural	9	9	9	9	9	9	9	9

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments for 2011 are preliminary and subject to change. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of provider of services files from CMS, 2011. Payment data are from CMS, Office of the Actuary.

- ASCs are entities that furnish only outpatient surgical services not requiring an overnight stay. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify minimum facility standards.
- In 2008, Medicare began using a new payment system for ASC services that is based on the hospital outpatient prospective payment system. ASC rates are less than hospital outpatient rates. In contrast to the old ASC system, which had only nine procedure groups, the new system has several hundred procedure groups.
- Total Medicare payments for ASC services increased by 4.9 percent per year, on average, from 2004 through 2011. Payments per fee-for-service beneficiary grew by 5.3 percent per year during this period. Between 2010 and 2011, total payments rose by 3.4 percent and payments per beneficiary grew by 2.5 percent.
- The number of Medicare-certified ASCs grew at an average annual rate of 4.1 percent from 2004 through 2011. Each year from 2004 through 2011, an average of 279 new Medicare-certified facilities entered the market, while an average of 80 closed or merged with other facilities.

Chart 7-19. Medicare spending for imaging services under the physician fee schedule, by type of service, 2010



Note: CT (computed tomography), MRI (magnetic resonance imaging), PET (positron emission tomography). Standard imaging includes chest, musculoskeletal, and breast X-rays. Imaging procedures include stereoscopic X-ray guidance for delivery of radiation therapy, fluoroguide for spinal injection, and other interventional radiology procedures. Medicare payments include program spending and beneficiary cost sharing for physician fee schedule imaging services. Payments include carrier-priced codes, but exclude radiopharmaceuticals. Totals may not sum to 100 percent due to rounding.

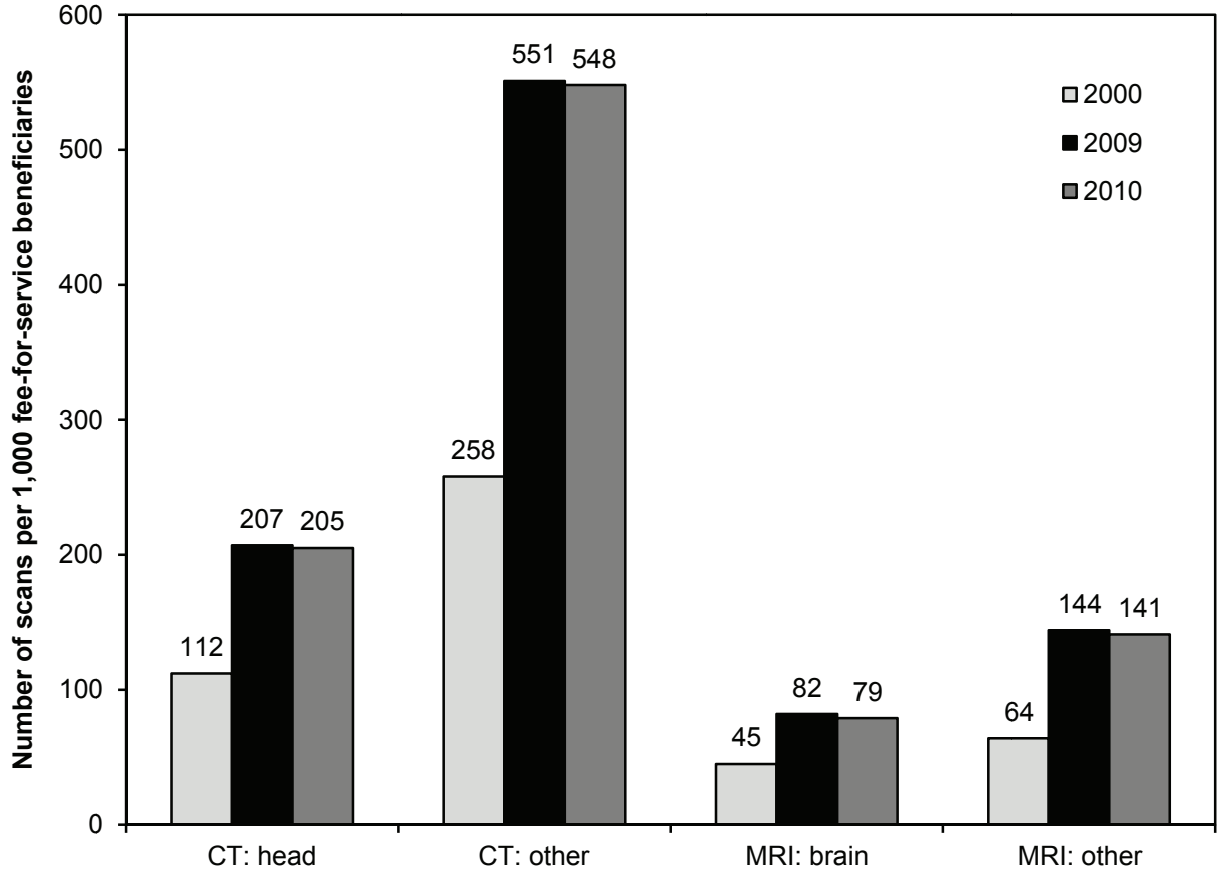
Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS, 2010.

- Over one-third of Medicare spending for imaging under the physician fee schedule in 2010 was for CT and MRI studies.

- Medicare and beneficiaries spent a total of $10.9 billion for imaging services under the physician fee schedule in 2010. Spending declined from $11.6 billion in 2009 (–5.4 percent). The decline in spending was largely due to the creation of new comprehensive codes for myocardial perfusion imaging (a type of nuclear medicine study), CMS's adoption of more current practice expense data from a new survey of practitioners, and an increase in the equipment use rate assumption for expensive imaging equipment, such as MRI and CT machines.

- Although spending for imaging services declined from 2009 to 2010, this decrease is small compared with the increases that occurred over the prior decade. From 2000 to 2009, cumulative growth in imaging spending totaled 80 percent (67 percent per fee-for-service beneficiary).

Chart 7-20. Rapid growth in the number of CT and MRI scans per 1,000 beneficiaries, 2000-2010



Note: CT (computed tomography), MRI (magnetic resonance imaging). Data include physician fee schedule imaging services.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary files from CMS, 2000, 2009, and 2010.

- The number of CT and MRI scans per 1,000 fee-for-service beneficiaries grew rapidly from 2000 to 2009. Despite a slight decline from 2009 to 2010, the number of studies in 2010 was still much higher than the level in 2000.
- For example, the number of CT scans of parts of the body other than the head more than doubled from 2000 to 2010 (from 258 per 1,000 beneficiaries to 548), despite a slight drop from 2009 to 2010.
- Similarly, the number of MRI studies of parts of the body other than the brain more than doubled from 2000 to 2010.

Web links. Ambulatory care

Physicians

- For more information on Medicare's payment system for physician services, see MedPAC's Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_Physician.pdf

- Chapter 4 of the MedPAC March 2012 Report to the Congress and Appendix A of the June 2012 Report to the Congress provide additional information on physician services.

  http://www.medpac.gov/chapters/Mar12_Ch04_CORRECTED.pdf
  http://www.medpac.gov/chapters/Jun12_AppA.pdf

- MedPAC's congressionally mandated report, *Assessing Alternatives to the Sustainable Growth Rate (SGR) System*, examines the SGR and analyzes alternative mechanisms for controlling physician expenditures under Medicare.

  http://www.medpac.gov/documents/Mar07_SGR_mandated_report.pdf

- Congressional testimony by the chairman and executive director of MedPAC discusses payment for physician services in the Medicare program. This includes:

  Payments to selected fee-for-service providers (May 15, 2007)
  http://www.medpac.gov/documents/051507_WandM_Testimony_MedPAC_FFS.pdf

  Options to improve Medicare's payments to physicians (May 10, 2007)
  http://www.medpac.gov/documents/051007_Testimony_MedPAC_physician_payment.pdf

  Assessing alternatives to the sustainable growth rate system (March 6, 2007)
  http://www.medpac.gov/documents/030607_W_M_testimony_SGR.pdf

  Assessing alternatives to the sustainable growth rate system (March 6, 2007)
  http://www.medpac.gov/documents/030607_E_C_testimony_SGR.pdf

  Assessing alternatives to the sustainable growth rate system (March 1, 2007)
  http://www.medpac.gov/documents/030107_Finance_testimony_SGR.pdf

  MedPAC recommendations on imaging services (July 18, 2006)
  http://www.medpac.gov/documents/071806_Testimony_imaging.pdf

  Medicare payment to physicians (July 25, 2006)
  http://www.medpac.gov/documents/072506_Testimony_physician.pdf

- The 2011 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds provides details on historical and projected spending on physician services.

  http://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf

- The Government Accountability Office issued a report in August 2009 about access to physician services within Medicare.

  http://www.gao.gov/new.items/d09559.pdf

- The Center for Studying Health System Change also conducts research on patient access to health care.

  http://www.hschange.org

Hospital outpatient services

- For more information on Medicare's payment system for hospital outpatient services, see MedPAC's Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_opd.pdf

- Chapter 3 of the MedPAC March 2012 Report to the Congress provides information on the status of hospital outpatient departments including supply, volume, profitability, and cost growth.

  http://www.medpac.gov/chapters/Mar12_Ch03.pdf

- Section 2A of the MedPAC March 2006 Report to the Congress provides information on the current status of hold-harmless payments and other special payments for rural hospitals.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02a.pdf

- Chapter 3A of the MedPAC March 2004 Report to the Congress provides additional information on hospital outpatient services, including outlier and transitional corridor payments.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf

- More information on new technology and pass-through payments can be found in Chapter 4 of the MedPAC March 2003 Report to the Congress.

  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch4.pdf

Ambulatory surgical centers

- For more information on Medicare's payment system for ambulatory surgical centers, see MedPAC's Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_ASC.pdf

- Chapter 5 of the MedPAC March 2012 Report to the Congress provides additional information on ambulatory surgical centers.

  http://www.medpac.gov/chapters/Mar12_Ch05.pdf